Schedule of Benefits

The Harvard Pilgrim POS

Services listed below are covered when Medically Necessary.
Please see your *Benefit Handbook* for details.

Your Plan offers two levels of coverage: In-Network and Out-of-Network.

In-Network Coverage

In-Network coverage applies to all your medical and health care needs provided or arranged by your Primary Care Physician (PCP). In-Network coverage also applies when you receive care in a Medical Emergency or when you use a Participating Provider for one of the special services that do not require a referral. A list of these special services can be found in your *Benefit Handbook.*

Out-of-Network Coverage

Out-of-Network coverage applies when you use a Non-Participating Provider, or when you use a Participating Provider without a referral when a referral is required for covered services.

Please refer to your *Benefit Handbook* for further information about how your In-Network and Out-of-Network coverage works.

Member Cost Sharing

Members are required to share the cost of the benefits provided under the Plan. The following is a summary of the cost sharing amounts under your Plan.

Your Plan has **Copayments** that are listed in the table below with the service to which they apply.

Hospital Inpatient Copayment:

- In-Network Medical: $400 per admission up to a maximum of 1 Copayment per calendar year quarter
- In-Network Mental Health and Substance Abuse: $200 per admission up to a maximum of 1 Copayment per calendar year quarter
- Out-of-Network Mental Health and Substance Abuse: $150 per admission (also subject to Deductible and Coinsurance)

Surgical Day Care Copayment:

- In-Network Surgical Day Care: $75 per admission up to a maximum of 1 Copayment per calendar year quarter

Hospital Inpatient Copayments and Surgical Day Care Copayments for Medical care accumulate only towards the Medical Out-of-Pocket Maximum.
Hospital Inpatient Copayments for Mental Health and Substance Abuse care accumulate only towards the Mental Health and Substance Abuse Out-of-Pocket Maximum.

Deductible:

- In-Network Medical: None
- In-Network Mental Health and Substance Abuse: None
- Out-of-Network Medical: $150 per Member, $300 per Family per calendar year
- Out-of-Network Mental Health and Substance Abuse: $150 per Member, $300 per Family per calendar year

The Deductibles for Medical accumulate separately from the Mental Health and Substance Abuse Deductibles.

Coinsurance:

- In-Network: None
- Out-of-Network Medical: 20% of Covered Charges after the Deductible is met until the Out-of-Pocket Maximum is reached.
- Mental Health and Substance Abuse: 20% of Covered Charges after the Deductible is met until the Out-of-Pocket Maximum is reached (also subject to a Copayment).

Out-of-Pocket Maximum:

- In-Network Medical: None
- In-Network Mental Health and Substance Abuse: $1,000 per Member, $2,000 per Family per calendar year
- Out-of-Network Medical: $3,000 per Member per calendar year
- Out-of-Network Mental Health and Substance Abuse: $3,000 per Member per calendar year

Please Note: In-Network Out-of-Pocket Maximums include Copayments and exclude Prescription Drug Copayments and Benefit Reductions. Out-of-Network Out-of-Pocket Maximums include Deductible and Coinsurance and exclude Copayments, Prescription Drug Copayments, Benefit Reductions, and any charges in excess of the Reasonable Charge. Separate Out-of-Pocket Maximums exist for Medical and for Mental Health and Substance Abuse.

Benefit Reductions:
Your benefits will be reduced by the amounts listed below, prior to the Plan paying for any Covered Charges:

- Out-of-Network Medical: $500 when the required Prior Plan Approval or Notification is not satisfied
- Out-of-Network Mental Health and Substance Abuse: $200 when the required Prior Plan Approval is not satisfied

You have annual calendar year **In-Network Copayment Limits** for the following services:

- 15 Outpatient Services per Member, including any combination of the following:
  - Office visits (excluding office visits for chiropractic services and outpatient mental health and substance abuse services)
  - Chemotherapy
  - Voluntary second or third surgical opinions
  - Cardiac rehabilitation
  - Infertility services
  - Early intervention services
  - Physical, occupational, and speech therapy services
  - Emergency care in a physician's office

Then, for the rest of that year, the $15 Copayment is waived for these Covered Services.

- In-Network: Hospital Inpatient Copayment, including all inpatient admissions, excluding Skilled Nursing Facility Care, inpatient mental health and substance abuse services and inpatient detoxification, a total of $400 per Member per calendar year quarter. (If you are admitted as an inpatient more than once per quarter, you will have the subsequent Copayments waived by the Plan during that quarter.)
- In-Network: Surgical Day Care Copayment, a total of $75 per Member per calendar year quarter. (If you have more than one Surgical Day Care admission per quarter, you will have the subsequent Copayments waived by the Plan during that quarter.)

	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Inpatient Acute Hospital Services		
All covered services, including the following: Coronary care Hospital services Intensive care Physicians' and surgeons' services including consultations Semi-private room and board (private room is covered when Medical Necessary) Private Duty Nursing	Subject to the Hospital Inpatient Copayment of $400 once per calendar year quarter.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Surgical Day Care Services		
All covered services, including the following: Hospital services Anesthesia services Endoscopic procedures, unless performed in the Hospital Outpatient Department Physicians and surgeons' services	Subject to the Surgical Day Care Copayment of $75 once per calendar year quarter.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Hospital Outpatient Department Services		
All covered services, including the following: Anesthesia services Chemotherapy Endoscopic procedures, unless performed in Surgical Day Care Laboratory tests and x-rays Physicians' and surgeons' services Radiation therapy	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.

* The definition of Reasonable Charge is included at the end of this table.

	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Physician Services		
All covered services, including the following: Chemotherapy Administration of injections Allergy tests and treatments Changes and removals of casts, dressings or sutures Consultations concerning contraception and hormone replacement therapy Diabetes self-management, including education and training Diagnostic screening and tests, including but not limited to, mammograms, blood tests and screenings mandated by state law Family planning services Health education, including nutritional counseling (limited to 3 visits for non-diabetes related conditions) Infertility services Medical treatment of temporomandibular joint dysfunction (TMD) Preventive care, including routine physical examinations, immunizations, routine eye examinations, school, camp, sports and premarital examinations Sick and well office visits Vision and hearing screenings	$15 Copayment per visit.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Administration of allergy injections	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Maternity Services		
Prenatal and postpartum care	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
All hospital services for mother and routine nursery charges for newborn	Subject to the Hospital Inpatient Copayment of $400 once per calendar year quarter.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.

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	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Home Health Care Services		
Home care services Intermittent skilled nursing care No cost sharing applies to durable medical equipment, physical therapy or occupational therapy received as part of authorized home health care.	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Emergency Room Care Services		
Hospital emergency room treatment You are always covered in a Medical Emergency. In a Medical Emergency, you should go to the nearest emergency facility or call 911 or other local emergency number. If you are hospitalized, you must call HPHC within 48 hours or as soon as you can.	$50 Copayment per visit. This Copayment is waived if admitted directly to the hospital from the emergency room**.**	
Emergency Admission Services		
Inpatient services which are required immediately following emergency room treatment	Subject to the Hospital Inpatient Copayment of $400 once per calendar year quarter.	
Skilled Nursing Facility Care Services		
Room and board, special services and physician services up to a maximum of $10,000 per calendar year	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Inpatient Rehabilitation Services		
Room and board, special services and physician services	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.

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	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Mental Health and Substance Abuse Services*		
Inpatient mental health services Inpatient substance abuse services Inpatient detoxification services	Subject to the Hospital Inpatient Copayment of $200 once per quarter.	Covered at 80% of the Reasonable Charge* after the Copayment of $150 per admission and the Deductible has been met.
Outpatient mental health and substance abuse services		
Individual therapy		
Visits 1 - 4 Visits 5 - 15	No Member charge. $15 Copayment per visit.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Visits 16 and over	$15 Copayment per visit.	Covered at 50% of the Reasonable Charge* after the Deductible has been met.
Group therapy Visits 1 - 4 Visits 5 - 15	No Member charge. $10 Copayment per visit.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Visits 16 and over	$10 Copayment per visit.	Covered at 50% of the Reasonable Charge* after the Deductible has been met.
Intermediate Services, including detoxification, acute residential treatment, crisis stabilization, day/partial hospital programs, 24 hour intermediate care facilities, therapeutic foster care and structured outpatient programs.	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Psychopharmacological services	$5 Copayment per visit.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Psychological testing and neuropsychological assessment	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.

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	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Dental Services		
Initial emergency treatment (within 72 hours of injury) Reduction of fractures and removal of cysts or tumors	The applicable Copayment will be determined by location of service.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Removal of 7 or more permanent teeth, excision of radicular cysts involving the roots of three or more teeth, extraction of impacted teeth, and gingivectomies of two or more gum quadrants Note: Benefits are provided for the dental services listed above only when the Member has a serious medical condition that makes it essential that he or she be admitted to a general hospital as an inpatient or to a surgical day care unit or ambulatory surgical facility as an outpatient in order for the dental care to be performed safely. Serious medical conditions include, but are not limited to, hemophilia and heart disease.	$400 Copayment for Hospital Inpatient services, limited to 1 Copayment per calendar year quarter. $75 Copayment for Surgical Day Care services, limited to 1 Copayment per calendar year quarter.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Diabetes Equipment and Supplies		
Therapeutic molded shoes and inserts, dosage gauges, injectors, lancet devices, voice synthesizers and visual magnifying aids	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Blood glucose monitors, insulin pumps and supplies and infusion devices	No Member charge.	
Insulin, insulin syringes, insulin pens with insulin, lancets, oral agents for controlling blood sugar, blood test strips and glucose, ketone and urine test strips	$10 Copayment for Generic items, a $20 Copayment for Select Brand items and a $40 Copayment for Non-Select Brand items for a 30-day supply.	

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	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Durable Medical and Prosthetic Equipment		
Durable medical and prosthetic equipment coverage includes, but is not limited to: Durable medical equipment Prosthetic devices Ostomy supplies	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Oxygen and respiratory equipment	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Wigs, when needed as a result of any form of cancer or leukemia, alopecia areata, alopecia totalis, or permanent hair loss due to injury – up to $350 per calendar year	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Other Health Services		
Ambulance services Lead testing Low protein foods - up to $2,500 per Member per calendar year State mandated formulas Dialysis Speech, language and hearing services including therapy	No Member charge.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Vision hardware for special conditions as described in your *Benefit Handbook*. There is limited coverage for eyeglasses or contact lenses needed as a result of the following special conditions: post cataract surgery with: 1) an intraocular lens implant or 2) without a lens implant, keratoconus and post retinal detachment surgery.	No Member charge up to the applicable benefit limits.	Covered at 80% of the Reasonable Charge* after the Deductible has been met, up to the applicable benefit limits.

* The definition of Reasonable Charge is included at the end of this table.

	In-Network Participating Providers with a referral when required.	**Out-of-Network** Non-Participating Providers or when you use Participating Providers without a referral when a referral is required.
Other Health Services Continued		
Cardiac rehabilitation Physical and occupational therapies - up to 90 consecutive days per condition House calls Early intervention services - up to a maximum of $3,200 per Member per calendar year and a lifetime maximum of $9,600 Reconstructive Surgery and Procedures Human Organ Transplants Medical services for TMJ Chiropractic services – up to a maximum of 20 visits per calendar year	$15 Copayment per office visit. $400 Copayment for Hospital Inpatient services, limited to 1 Copayment per calendar year quarter. $75 Copayment for Surgical Day Care services, limited to 1 Copayment per calendar year quarter.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Coronary Artery Disease (CAD) program – see the *Benefit Handbook* for benefit details	90% of charges.	Not Covered.
Hospice services	No charge for outpatient care. If inpatient services are required, please see "Inpatient Acute Hospital Services" for cost sharing.	Covered at 80% of the Reasonable Charge* after the Deductible has been met.
Hearing aids – once every two years	Covered at 100% for the first $500, and 80% for the next $1,500.	
Prescription drug coverage	Retail: $10 Copayment for Generic, a $20 Copayment for Select Brand and a $40 Copayment for Non-Select Brand prescriptions for up to a 30-day supply. Mail Order: $20 Copayment for Generic, a $40 Copayment for Select Brand and a $80 Copayment for Non-Select Brand prescriptions for up to a 90-day supply.	

*Reasonable Charge: In the judgment of HPHC, an amount that is consistent with the normal range of charges by health care providers for the same, or similar, products or services in the geographical area where the product or service was provided to a Member. If HPHC cannot reasonably determine the normal range of charges where the products or services were provided, HPHC will utilize the normal range of charges in Boston, Massachusetts. The Reasonable Charge is the maximum amount that the Harvard Pilgrim POS plan will pay for Covered Benefits.

Special Enrollment Rights

If an employee declines enrollment for the employee and his or her dependents (including his or her spouse) because of other health insurance coverage, the employee may be able to enroll in this plan in the future along with his or her dependents, provided that enrollment is requested within 30 days after other coverage ends. In addition, in the case of divorce, or if the employee has a new dependent as a result of marriage, birth, adoption or placement for adoption, the employee may be able to enroll along with his or her dependents, provided that enrollment is requested within 30 days after the marriage, divorce, birth, adoption or placement for adoption.

Required Prior Plan Approvals and Notifications

- **Services that require Prior Plan Approval**

  Prior Plan Approval is required for the services listed below, to assure full payment of benefits. Please remember that if Prior Plan Approval is not obtained, your benefits will be reduced by $500 for medical services or $200 for mental health or substance abuse services if you receive care from a Non-Participating Provider or from a Participating Provider without a referral when a referral is required. Please note, however, that there is no obligation to cover a service that is determined NOT to be Medically Necessary or if it does not meet the Plan's clinical criteria.

  This requirement applies to the following procedures and services, including but not limited to:

  Procedures

  - Blepharoplasty - plastic surgery on an eyelid especially to remove fatty or excess tissue. This procedure is sometimes done in conjunction with Ptosis repair when the excess tissue is due to a medical disease.
  - Bone marrow transplant/stem cell transplant
  - Breast implant removal
  - Breast reduction mammoplasty
  - Cosmetic procedures (includes Scar Revision and other potentially cosmetic services)
  - Gastric stapling/gastric bypass (bariatric surgeries)
  - Laminectomy/Discectomy – procedures done on the vertebra in the back usually for disc disease.
  - Mandibular/Maxillary osteotomy – surgical procedures to realign the jaw, usually for patients with obstructive sleep apnea.
  - Odontectomy - the removal of teeth by the reflection of a mucoperiosteal flap and excision of bone from around the root or roots before the application of force to effect the tooth removal.
  - Panniculectomy - a procedure to remove fatty tissue and excess skin from the lower to middle portions of the abdomen. This procedure is indicated in some individual's who have lost considerable weight resulting in loose hanging folds of skin in the abdominal area.
  - Port wine stain laser treatment
  - Ptosis repair - a procedure to repair the sagging or a drooping of the upper eyelid such that the drooping eyelid impairs the vision as measured by a visual field test.
  - Rhinoplasty – plastic surgery to change the shape or size of the nose.
  - Septoplasty – surgical procedure to correct defects or deformities of the nasal septum.
  - Temporomandibular joint (TMJ) treatment
  - Uvulopalatopharyngoplasty (UPPP) - a surgical procedure to remove excess soft tissue surrounding the uvula, soft palate, and tonsils to create a wider opening in the back of the mouth to improve sleep apnea.
  - Varicose vein excision and ligation

  Services

  - Advanced reproductive technology (ART)
  - Home health care, including home infusion and home hospice
  - Infant formula
  - Inpatient and Surgical Day Care dental care, extractions and oral or periodontal surgery
  - Inpatient rehabilitation care, including inpatient pulmonary rehabilitation
  - Inpatient skilled nursing care (SNF)
  - Intra-facility admissions (transfers)

- Outpatient enteral nutrition
- Outpatient pulmonary rehabilitation
- Mental Health and Substance Abuse services
- Speech/language therapy
- Vision hardware for special conditions (including post cataract surgery with: 1) an intraocular lens implant or 2) without a lens implant, keratoconus and post retinal detachment surgery)

- **Services that require Notification**

  Notification is required for the services listed below to assure full payment of benefits. Please remember that if Notification is not made, your benefits will be reduced by $500 for medical services or $200 for mental health or substance abuse services if you receive care from a Non-Participating Provider or from a Participating Provider without a referral when a referral is required. Please note, however, that there is no obligation to cover a service that is determined NOT to be Medically Necessary.

  The following services require Notification:
  - A medical admission to an inpatient facility, including admissions for maternity care except for those procedures or services noted in the Prior Plan Approval section.
  - Day Surgery, except for those procedures or services noted in the Prior Plan Approval section.
  - Human organ transplants, except for bone marrow or stem cell transplants (see Prior Plan Approval)
  - Outpatient physical and occupational therapy services

- **Maternity Care**

  Members who are pregnant, and using a Non-Participating Provider, are responsible for calling the Brighter Infant Beginnings Program, at 1-800-742-2423, after the first prenatal visit.

Benefit Exclusions

The Plan does not provide coverage for:

- A service, supply, or medication if there is a less intensive level of service supply, or medication or more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided to you in a less intensive setting
- Acupuncture, aromatherapy, and alternative medicine
- All charges over the semi-private room rate, except when a private room is Medically Necessary
- Any form of surrogacy
- Any home adaptations, including, but not limited to, home improvements and home adaptation equipment
- Any services not specified in this *Handbook* and your *Schedule of Benefits*
- Blood and blood products
- Care by a chiropractor that falls outside the scope of standard chiropractic practice, including but not limited to, surgery, prescription or dispensing of drugs or medications, internal examinations, obstetrical practice, treatment of infectious disease, or treatment with crystals. Diagnostic testing for chiropractic care other than an initial x-ray.
- Charges for any products or services, including, but not limited to, professional fees, medical equipment, drugs, and hospital or other facility charges, that are related to any care that is not a Covered Benefit under this *Handbook*
- Charges for missed appointments
- Charges for services received after the date on which your membership ends
- Commercial diet plans, weight loss programs, and any services in connection with such plans or programs
- Dental services, except the specific dental services listed in this *Handbook*. Restorative, periodontal, orthodontic, endodontic, prosthodontic and dental services for temporomandibular joint dysfunction (TMJ) are not covered. Removal of impacted teeth to prepare for or support orthodontic, prosthodontic or periodontal procedures and dental fillings; crowns; gum care, including gum surgery; braces; root canals; bridges; bonding and dentures.
- Dentures
- Devices and procedures intended to reduce snoring including, but not limited to, laser-assisted uvulopalatoplasty, somnoplasty, and snore guards
- Devices or special equipment needed for sports or occupational purposes
- Drugs, devices, treatments or procedures that are Experimental or Unproven
- Educational services or testing, (except such services covered under the benefit for Early Intervention) or services for school performance
- Electrolysis, routine foot care services, biofeedback, hypnotherapy, psychoanalysis, pain management programs, massage therapy (including myotherapy), sports medicine clinics, services by a personal trainer, cognitive rehabilitation programs, and cognitive retraining programs

- Eyeglasses, contact lenses and fittings, except as listed in your *Schedule of Benefits* as well as this *Handbook*
- Hair removal or restoration, including, but not limited to, electrolysis, laser treatment, transplantation or drug therapy
- Hospital charges with dates of service after your hospital discharge
- Infertility treatment for Members who are not medically infertile
- Mental health services that are (1) provided to Members who are confined or committed to a jail, house of correction, prison, or custodial facility of the Department of Youth Services; or (2) provided by the Department of Mental Health
- Non-durable medical equipment, unless used as part of the treatment at a medical facility or as part of approved home health care services
- Personal comfort or convenience items (including telephone and television charges); non-durable medical supplies, unless used in the course of diagnosis or treatment in a medical facility or in the course of authorized home health care; exercise equipment; electronic and myoelectric artificial arms and legs; derotation knee braces; and repair or replacement of durable medical equipment or prosthetic devices as a result of loss, negligence, willful damage, or theft
- Physical examinations or services for insurance, licensing or employment purposes which are not otherwise Medically Necessary
- Planned home births
- Preimplantation genetic testing and related procedures performed on an embryo
- Preventive dental care
- Refractive eye surgery, including laser surgery and orthokeratology, for correction of myopia, hyperopia and astigmatism
- Rest or Custodial Care
- Reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal) and the costs of achieving pregnancy through surrogacy
- Sclerotherapy for treatment of spider veins
- Sensory integrative praxis tests
- Services for a newborn who has not been enrolled as a Member, other than nursery charges for routine services provided to a healthy newborn for up to 30 days after the newborn's birth
- Services for cosmetic purposes, except as described in this *Handbook* for post-mastectomy services or reconstructive surgery
- Services for non-Members and services after membership termination
- Services for which no charge would be made in the absence of insurance
- Services for which payment is required to be made by a Workers' Compensation plan or an employer under state or federal law
- Services for which you are legally entitled to treatment at government expense. This includes services for disabilities related to military service.
- Services or supplies given to you by: (1) anyone related to you by blood, marriage or adoption, or (2) anyone who ordinarily lives with you
- Services that are not Medically Necessary

- Therapeutic molded shoes and foot orthotics, except for the treatment of severe diabetic foot disease
- Transportation other than by ambulance
- Transsexual surgery and all related drugs and procedures
- Vocational rehabilitation, or vocational evaluations on job adaptability, job placement, or therapy to restore function for a specific occupation

1600 Crown Colony Drive
Quincy, MA 02169